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## Original Department.

### Communications.

### I. PUERPERAL CONVULSIONS. II. FRACTURE OF CRANIUM.

By H. L. W. Burritt, M. D.,

Of Bridgport, Conn.

#### I. PUERPERAL CONVULSIONS.

Mrs. B——, German, æt. 28, primapara, thin in flesh and of delicate health, though doing the usual work of a small family; of bilio-nervous temperament. I had seen her on Saturday, and found her complaining of wandering pains; but she said her time was not up for a month yet; slight œdema of the feet—nausea; bowels free, tongue clean, pulse 80 and feeble; urine, by account, copious. She was suffering from extreme mental anxiety about the result of her confinement, and general restlessness. I told her she would be sick soon, and assured her she need not feel anxious about the result, as her symptoms were not unusual. Gave her, to allay the excitement and nausea, morphiæ ¼ grain in syrup of ginger.

At 12 M. next day, Sunday, I was sent for in haste; found her with regular, strong pains, extremely anxious, and with a bad countenance; pulse 75 and strong; head on the perineum, and the child was born with slight effort in ten minutes after, patient saying "shall I die, doctor, shall I die," constantly. The after-birth was delivered immediately, fearing convulsions. Two minutes after she heard the infant cry, and said her last words, "is that the child?" when there was a little bloody froth at the mouth and rattling in the throat; cold water was dashed in the face, ammonia and camphor applied to the nostrils; there was a slight contraction of one arm and a twitch of the face—no more; pulse 50, countenance obtuse, pupils very small, respiration gasping. The pulse fell in a minute to 30, but full; she was apparently moribund. I rapidly opened a vein and bled to 20 ounces, when the heart beat was 100 and full, and the breathing freer for about an hour; in the meantime an injection of bromide potass. ʒij. aquæ ʒiv. was given and retained; but the symptoms of distress returned. She would cease to breathe for twenty seconds, then, with a slight spasm, rapid breathing accompanied by an expulsion of bloody froth and mucus would follow, and for a few minutes she would be easier, when the intermission would return and go on as before; pulse variable 50–100. She lived perfectly unconscious, with closely contracted pupils, for five hours in this condition, mustard, warm applications, etc., being freely used. The labor was very short and favorable. The flow very free indeed, but the bad result seemed so plainly the effect of mental disturbances that the experienced old women around said, *she was frightened to death.* Was it congestion of the brain or pulmonary apoplexy?

#### II. FRACTURE OF CRANIUM.

Mrs. B., an Irish woman, æt. 30; mother of three children, of spare habit; coming down a short pair of outside steps, fell about six feet and was thrown against a stone wall. A sharp edge penetrated through and fractured the parietal bone of the left side. I saw her half an hour after the accident, and found her comatose, pupils contracted, pulse 65 and very small. She had lost a large quantity of blood for such an injury.

On an examination, by passing a finger into the wound, I could distinctly feel a fracture extending downward and forward for three

inches into the temporal bone, as far as followed. Blood flowed in small quantities constantly from the ear, and the injury was evidently extensive and the result doubtful. Ice water was applied freely to the whole cranium, and hot infusions of capsicum and mustard to the lower extremities. The second day she showed a little more sensibility, and with difficulty three teaspoonfuls of the following mixture were given:

℞. Tinct. aconite, ℥ijss.
Bromid. potass., ℥iv.
Syrup simp., ℥j. M.

The bladder on trial was found empty, pulse 100, pupils contracted; she showed no feeling on probing the external wound or tickling the feet.

*Third day*—Pulse 90, pupils dilated more than yesterday by shaking and great care, she has taken the medicine every six hours and a little water; small quantity of urine passed involuntarily; external applications continued; surface of the body still cool.

*Fourth day*—Patient can be nursed with difficulty, but does not seem to recognize any one; medicine and water gruel given at intervals. Pulse 90, skin cool, urine passed in small quantities. There is a constant discharge of mingled watery pus and blood from the ear, about a tablespoonful in twenty-four hours. Pupils assuming a more natural appearance. Ophthalmoscope showed not very marked congestion of the retina.

*Fifth day*—Pulse 75, skin natural, feet warm for the first time since the injury; nausea for the first time under the large doses of the aconite (15 drops every six hours) and bromide; no recognition of friends, but can be roused by touching the wound which suppurrates freely.

*Sixth day*—Pulse 60, skin warmer, respiration easier and more of a voluntary character; medicine diminished one half; swallows freely lemonade and gruel, no stronger nourishment being allowed.

*Seventh day*—Patient spoke for the first time and knew those about her. But there appeared to be a slight paralysis of the vocal cords and the voice very weak. Discharge from the ear continues, but lessened; wound nearly healed, with some small exfoliations of bone.

Patient continued to improve, and is able at this date, Nov. 4th, four weeks after the injury, to be around a little, though weak.

The peculiarity of the case is the recovery after so severe an injury to the cranium and brain as indicated by the aural discharge and the symptoms generally. The result was due largely to the vent by the ear, and the powerful sedative effect of the aconite and bromide of potassium.

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## INTRA-UTERINE FIBROUS TUMOR—PARTIALLY REMOVED—DEATH THIRD DAY.

By W. Symington Brown, M. D.,

Of Stoneham, Mass.

It is clearly the surgeon's duty to report unsuccessful operations as faithfully as successful ones.

I visited Mrs. S. at her house in Hyde Park, Mass., in May, 1870, and made a pretty thorough examination of her case. With a small frame, delicate organization, nervous temperament, and possessing in a remarkable degree courage, decision and self-control, her features bore the traces of long-continued suffering, the cheeks sunken and sallow. A large, firm tumor, apparently solid, occupied the lower half of the abdomen; a stout uterine-sound, after several trials, passed about three inches, and the whole mass could be moved slightly from side to side by means of the sound thus inserted. The tumor was evidently uterine, and, if not incorporated with the uterine walls, at least partially adherent. The os was not open enough to admit a finger.

The patient had been under the care of several irregular practitioners for a number of years, without relief. She was subject to periodical attacks of hemorrhage, and was much reduced in strength. It was not till the following August that a somewhat similar case (Mrs. B., of Peabody) came under my care, which was successfully operated upon, and the tumor entirely removed by means of Dr. Cutter's modification of the wire ecraseur,* and under these circumstances I counselled non-interference by operation.

I did not see her again till July 22, 1871, more than a year after my first visit. She had tried quite a number of empirical remedies—among others the so-called "vacuum cure," bearing the pain and distress attendant thereupon with heroic fortitude; the hemorrhage had increased in frequency and severity,

*Reported in the *Gynæcological Journal* for Feb., 1871. Also in Medical and Surgical Reporter, Aug. 5, 1871.

and she was now prepared to submit to any surgical operation which might afford a chance of cure. She had heard of Mrs. B.'s case, and was encouraged to hope for the best.

The uterus was progressively dilated by means of sponge tents; and on the following Monday, with the assistance of Dr. CUTTER, of Woburn, an attempt was made to remove the tumor. After withdrawing the last tent, the patient was anæsthetised with sulphuric ether, and the uterine neck still further dilated, first by means of forceps, and then with a BARNES' dilator filled with water. There was no difficulty in effecting dilatation; the trouble, as in the preceding case, was to keep it dilated. Finally, two fingers could be inserted into the cervix, and the presence of a large adherent tumor plainly detected. We used one of CHARRIERE'S large ecraseurs, minus the chain, with CUTTER'S curved tube and wire attachment, and managed to remove two pieces about the size of figs.

The patient had now been under the influence of ether for nearly three hours, and was much exhausted, although but little blood had been lost. The available space was so contracted that there was not sufficient room for fingers and curette to separate the growth from the uterine walls. We therefore concluded to postpone further proceedings for a time, leaving her in care of Mrs. Dr. BROWN, who had prepared her for the operation, and remained with her till the end. She rallied well, and passed a comfortable night. She had a slight chill on Tuesday evening; a more severe one on Wednesday forenoon; and died at eleven o'clock on Wednesday evening.

*Post mortem, 12 hours after death.*—The features were so much swollen as to be scarcely recognizable; and the entire body was bloated. Only the abdomen was examined. There was very little fluid in the peritoneal cavity. The uterus was not adherent at any part; and the whole organ, with ovaries and appendages, was removed. The tumor is a good specimen of the fibrous variety; the main portion consists of muscular fibres, resembling those of the gravid uterus, interspersed with a considerable quantity of connective tissue. A recent section presented the appearance of fine mahogany veneer, rose tinted, the connective tissue forming the white veins. Examination with the microscope corroborated these appearances, and showed that the growth was not malignant.

Although the tumor is adherent throughout the greater part of its surface (the result, probably, of previous inflammation), I think that if the operation had been performed in 1870, when the patient's strength was greater, that it would have proved successful. The adhesions might have been broken up, and the mass removed in sections.

## HOSPITAL REPORTS.

### UNIVERSITY OF PENNSYLVANIA.

Surgical Service of Prof. AGNEW.

[REPORTED BY DR. DE F. WILLARD.]

**Urinary Calculi—Lithotomy, Two Cases.**

GENTLEMEN.—Two cases which have come to us, one from North Carolina, the other from New Jersey, give me, now, the opportunity of demonstrating to you the operation of lithotomy, as well as making a few remarks upon the subject of calculus.

These concretions, I am convinced, are usually renal in their origin, although they may form in the bladder, if a nucleus is provided for them, as a pebble, straw, pencil, etc. (frequently introduced by thoughtless children), or, again, from a broken catheter. Those having a nucleus of urates or oxalates are usually considered to have the former origin, of phosphates the latter. The cause of formation is due to a constitutional diathesis, which is associated with some disorder of the digestive system, or to mal-assimilation. The most common of these diatheses are the lithic, oxalic and phosphatic, the conditions which give rise to cystic oxide, uro-stealith, melanourine, etc., being as yet undetermined.

The first two of these deposits are derived from the organic or animal elements of the urine; the phosphates from the inorganic. Their formation into a calculus is either by an aggregation about some insoluble deposit, or around a foreign body, the act of deposition being, as remarked by VON WALTHER, partly a chemical crystallization and partly an organic growth, the different particles being held and fastened in position by animal matter, the primary cause being usually an excess in the insoluble materials of the urine.

The uric acid diathesis is dependent upon a too great supply and too little waste of nitrogenized materials, associated with impairment of digestion, as seen in indolent, high livers most markedly. The color of these deposits, and of its salts, the urates, varies from almost white to a deep red; the latter color being due to the presence of purpurine. Uric acid deposits crystallize in the shape of rhombic

prisms, or lozenge shaped plates, while the urates form globular masses (soda), or acicular crystals (magnesia).

The oxalitic is regarded by some as a modification of the uric acid diathesis, while others consider it as due to impaired digestive functions, or exhausted nervous energy, and as one of the secondary products of the oxidation of saccharine materials of the body, being somewhat allied to that peculiar tendency to the formation of sugar which gives rise to the disease known as diabetes. Oxalates assume the form of octahedral, or of dumbbell crystals, the latter of which, when aggregated, form the nucleus to the "hemp seed" calculi.

The phosphates, as I have said, are inorganic in their origin, and are usually found associated with an alkaline condition of the urine, and in broken down anæmic conditions. They are found in two forms: phosphate of lime and ammonia-phosphate of magnesia, or triple phosphate; the former depositing in six-sided prisms, the latter in prisms, plates or stellate crystals. These, in combination, form the "mixed or fusible calculus."

When any of these deposits are aggregated in small masses, they give rise to the condition known as gravel; but of this we have not time to speak, neither can we enter upon a discussion as to the merits of various remedies proposed for the correction of the several diatheses. These may well occupy us at some future clinic.

These little gravel stones may pass on out the urethra, but when once an aggregation is formed, crystallization and deposition of the var ous substances in the urine are very apt to occur—just as you have often seen upon bodies suspended in a solution of alum or other salts. This deposition or growth takes place in successive layers, which are often of different materials, giving rise to the calculi known as "alternating," *i. e.* we may have a nucleus of uric acid, then a layer of phosphates, and then uric acid again; or again, phosphates and oxalates may be found in different strata of the same stone.

Uric acid calculi are usually hard, small, oval, of a brown or fawn color, and smooth upon their surface, while the oxalate of lime, or mulberry concretions, are rough, angular, jagged, very hard, and of a dark-brown or black color.

The phosphatic are irregular and contorted, have a chalky appearance; but although the largest in size, yet are lighter in weight, and quite soft

The color of a calculus shows the nature of its external coat simply—the interior being frequently entirely different. As a rule (though subject to some variations), a white surface shows a phosphatic crust; a yellow-brown or brown, uric acid; a cinder gray, urate of ammonia; cinnamon-brown, uric or xanthic oxide; brown, brownish or blackish-green, oxalate of lime; gray-green, cystic oxide, etc.

These stones may vary n weight from a few grains to one mentioned by COULSON (Uytterhœven), which exceeded 6 pounds.

The uric acid are the most common, being found in nearly two-thirds of all cases.

A calculus generally forms, as I have said, in the kidneys, and soon gives rise to uneasiness and pains in the loins with occasional mild attacks of colic, until it finally slips into the ureter occasioning that severe suffering known as nephitic colic, or the descent of a stone *from the kidney* to the bladder. This pain is of the most agonizing character, extending down the spermatic cord to the testis, and even down the thigh, accompanied by violent spasmodic contraction of the cremastes muscle, nausea, constipation, a sense of constriction at the umbilicus, with rigor and extensive prostration if long continued.

These symptoms are almost diagnostic, being simulated only by some forms of irritation or distension of the cæcum or descending colon. For the relief of these pains, hot hip baths and opium may be fully tried, but I prefer the immediate administration of ether, as being quicker in its operation and tending, also, to more complete relaxation.

As the concretion slips into the bladder, the symptoms rapidly subside, and the indication now is to endeavor to wash it out of the urethra as quickly as possible, before it attains to any greater size. For this purpose diuretics should now be freely given (never while the stone is in the ureter, damming it up), and the man directed to place himself in different positions while urinating, in order that gravity may bring it into the grasp of the urethra.

Should the calculus remain, however, it constantly increases in size, and soon gives rise to the symptoms of which both these men before us complain. In one of these cases, a man, 27 years of age, the concretion seems to prove what is mentioned by STAHL, that it may be congenital, for the patient informs us that he has had symptoms of vesical irritation even from his earliest infancy. In the other case, a man of 34 years of age, they have existed for several years, but not severely until about twenty-five months since.

The symptoms are those produced largely by mechanical irritation, *i. e.*, pain in the bladder and perineum, with a weary sensation in the groins, pain at the end of the penis, frequent micturition, sudden stoppage of the current, followed by a free flow, bloody or thick urine at times, tenesmus and prolapse of the rectum, and sometimes priapism. These are all present in varying degrees in both these patients, but in the first mentioned one, they have not been so severe of late, a fact which can only be accounted for by the encysting of the calculus, a condition which occasionally occurs.

Any or all of these symptoms may be present in various irritations of the urinary passages, but we have a means of diagnosis which is invaluable, that is, physical explora-

tion with the "sound," a steel instrument admirably adapted to this purpose. A catheter is not good, since it is a poor conductor of sounds.

The pain at the end of the penis is so great, that there is a constant tendency, especially in children, to pull at the prepuce, thus elongating it, and often producing partial phymosis. This pain, you must remember, is not necessarily a sign of stone in the bladder, for it is often present in cystitis, etc.; but in cases of calculus, it is usually more persistent, owing to the constant continuance of the cause.

When the patient exercises violently, or takes cold, all the symptoms become exaggerated, and are accompanied by fever and general constitutional disturbance, known as a "fit of the stone," requiring full doses of opium by the rectum, with warm fomentations or baths, and sometimes anæsthetics.

I have sounded these men, and know that a stone is present in each case; yet, I will again test them, both since it is an invariable rule never to commence the operation of lithotomy unless the calculus can be felt at the time; and also that you may hear and know for yourselves.

The sound is oiled, warmed, and gently carried into the bladder, in the same manner that I showed you a few weeks since with the catheter [*vid.* REPORTER, Oct. 14th, 1871], and now moving the point about the viscus in all directions, I feel a hard, rough substance. With this sounding-board attached to the handle, I am sure the click can be heard in all parts of the room. In one of the cases I think the stone is quite large; in the other I am uncertain—it is not small, however. Sounds should be of various shapes, so as to reach in all parts of the bladder, since calculi may be encysted in any portion, or may be caught in folds of the mucous membrane. If a stone is not discovered at one sitting, try again, or change the position of the patient. The size of a calculus may be determined with a lithotrite. Do not mistake calcareous deposit in the prostate for a stone. You may also be misled by large, deformed, sacculated or fasciculated bladders. A finger in the rectum will often be of great service.

These patients have been under treatment for several days, and have been allowed to rest from the fatigue of their journeys hither. Their secretions and functions have been all placed in proper condition, and mild alkaline drinks of soda bicarb. and inf. uvæ ursi constantly given, with suppositories of 1 grain of opium and two of ext. hyoscyami at night.

The bowels were opened with castor oil on yesterday, and about an hour since the rectum was freely washed out with an enema of warm water, since when the risk of its being cut is increased.

There is one other very important thing to be done before we decide upon any operation, and that is the examination of the urine, both chemically and microscopically, for should we find any evidences of severe renal disease behind this difficulty, I should decline the operation; and I am satisfied that many of the deaths from lithotomy are caused by a neglect of this precaution.

Such an examination has been made, and although there has been found in the first case a considerable deposit of blood, pus and mucus, yet there are no casts, either fatty, granular or epithelial, and there is no more albumen than would be accounted for by the blood which is present. These substances then are evidently from the bladder itself, and are, therefore, but the direct results of the constant irritation. In the second case, also, there are no evidences of any renal trouble at all, so that I feel reassured, knowing that there are good kidneys to assist us.

I have decided to perform the "lateral" operation of lithotomy—the one usually known as that of CHESELDEN, and of this operation only I will now speak, leaving other forms for future description, as cases present themselves.

The first and foremost requisite in lithotomy is a thorough knowledge of the anatomy of the parts involved; yet this is a point too often neglected by surgeons. Let us study it thoroughly. The perineum is a lozenge-shaped space, bounded behind by the coccyx, in front by the pubis, and upon the sides by the rami of the pubes and ischia, and the sacro-sciatic ligaments; or, in other words, its boundaries would correspond to a line defining the inferior strait of the pelvis. It is four inches long, three wide, and is divided into two portions—the anterior or urethral or true perineum, and the posterior or anal. The posterior is divided by the bowel into two fossa, the ischio-rectal, triangular-shaped cavities, bounded on the outside by the obturator fascia, covering the obtur. int. muscle; on the inside by the delicate levator ani fascia; in front by the middle perineal fascia, of which I shall presently speak; behind by the gluteus maximus and great sacro-sciatic ligament.

The apex of this triangle is at the junction of the obturator and levator ani fascias, several inches up from the surface, and this whole space is filled with loose connective tissue and fat, in which we also find the inferior hemorrhoidal arteries, veins and nerves.

The anterior or urethral perineum is most important, and I will dissect this accurate model before you.

The anterior portion is all that part front of a line connecting the ischiatic tubers. It is triangular in shape, and is divided into two equal portions by the raple or median line. First I take off the skin, and then come directly upon this mass of connective tissue and fat, which is the superficial perineal fascia, continuous with the superficial fascia of the thighs and abdomen. Students, I find have but an indefinite idea as to these fascias of the perineum. But

I think the matter can be made perfectly simple by calling them all perineal fascias, just as we speak of the pectoral fascias.

I divide them into *superficial, middle and deep perineal* fascias. The superficial I have already described—it is the same as that found in other portions of the body. The next is the *middle perineal fascia*, and I show it to you on the model as a white membrane covering all the muscles at the root of the penis. It is attached to the rami of the pubes and ischia, external to the crura of the penis, as far back as the tuberosities; is continuous with the dartos structure of the scrotum in front, and, behind, arches down behind the transversus perinei muscles to join the anterior layer of the deep perineal fascia, thus forming a division between the anterior and posterior perineum. This is the fascia which prevents extravasation of urine in cases of rupture of the anterior portion of the urethra, permitting it only to pass forward into the scrotum or up upon the abdomen.

Beneath this fascia are the transversus perinei, accelerator urinæ and erector penis muscles, the superficial and transverse perineal arteries, the superficial, perineal and inferior pudendal nerves, and to the outside, concealed in a groove of the ramus of the ischium, are the internal pudic vessels and nerves.

*The deep perineal fascia, or triangular ligature.*—I now show you upon the model, having removed all the above mentioned structures. It is the anterior closure of the inferior pelvic strait, and is the boundary of this space which we are studying. It is a dense membrane, firmly attached to the symphysis, sub-pubic ligament, and rami of the pubes and ischia, beneath the crura penis. Behind it is attached the middle perineal fascia, as before mentioned, by its anterior layer, while the posterior (for there are two, one arising from the anterior lip of the rami, the other from the posterior), curves upward, and is lost in the recto-vesical connective tissue. The point where all these structures converge, is called the "tendinous centre of the perineum."

Between these two layers of the triangular ligament lie the membranous part of the urethra, the dorsal vein of the penis, the compressor urethræ muscle (the muscles of WILSON and GUTHRIE), COWPER'S glands and their ducts, the pudic ves els and nerve, the artery and nerve of the bulb and a plexus of veins.

The crura of the penis arise from the rami of the ischia in front of this fascia, and behind it are the vesiculæ seminales, prostate gland, vas deferens and neck of the bladder.

Now in the lateral operation for lithotomy you will necessarily cut many of these structures, and in the following order: skin, superficial fascia, external hemorrhoidal vessels and nerve, superficial perineal vessels and nerve, middle perineal fascia, transverse perineal muscle and artery, posterior portion of the accelerator urinae muscle, anterior fibres of the levator ani, deep perineal fascia or triangular ligament, part of the compressor urethrae, the membranous and prostatic portions of the urethra, the prostate gland, the plexus of veins, and the neck of the bladder. The transverse perineal artery may require a ligature. The prostatic plexus of veins seldom yield any severe hemorrhage. Should this occur, as it sometimes does in old persons or when the veins are enlarged from long irritation, they cannot be tied, but the hemorrhage must be controlled by plugging deep into the wound around a catheter, muslin being attached to it, forming an umbrella, so that all the bits of sponge or muslin can be readily removed; oozing may be controlled by ice. The accessory pudic or the artery of the bulb should not be injured unless they are abnormal in their course. If the edge of the knife is carried too far out, the internal pudic may be cut, which will give serious hemorrhage, and is difficult to reach except with a curved needle. It may be compressed by a finger until the operation is completed.

The dangers are: in front the corpus spongiosum, if the beginning of the incision is made too freely near the median line, and deeper down the artery of the bulb; outside, the pudic vessels; inside, the rectum; behind, if the incision is carried too far through the prostate gland, the prostatic fascia, thus allowing extravasation of urine into the connective tissue which is in close proximity to the recto-vesical fold of peritoneum. This tissue is, in fact, so loose that operators have worked their way up into it and not entered the bladder at all.

The incision for this operation should commence a little to the left of the median line an inch and a quarter in front of the anus, and extend outward to a point on the line with, but a little nearer to the tuberosity of the ischium than to the anus, so as not to injure the rectum. This will, of course, connect both anterior and posterior perineums. The knife must be kept well *lateralized*, so as not to be quite parallel with the ramus.

A low table is preferable for the operation. The necessary instruments are a grooved staff, a long, narrow, straight, very sharp bistoury, forceps, scoops, syringe, and gum catheter. The stone being felt, the bladder is injected with six ounces of warm flaxseed mucilage, and the staff introduced, which should be entrusted only to a skillful assistant. He must hold it firmly and steadily in position, just against the arch of the pubis, and with the groove a little to the left.

The other assistants required are: one to administer to and watch over the ether, and one to each leg, which is better than tieing, and one to hand the instruments, sponge, etc., five in all.

As soon as skin and superficial fascia are cut through, the finger must be introduced into the wound, and there it should remain

until the bladder is reached, guarding and guiding the point of the knife, and especially protecting the rectum, which is so liable to be cut. When the staff can be felt, the nail is caught in its edge, and the knife inserted into the groove. The staff is still held by the assistant in exactly the same position, while the operator, with one thrust, divides all the structures from the triangular ligament to the neck of the bladder, when a gush of urine ensues. The edge of the knife is here, also, as it has been since the commencement o the operation, kept well lateralized, to avoid the rectum, and care is taken not to incise the prostate too freely. The aperture can be dilated with more safety. Some surgeons prefer the gorget for this step of the operation, but I do not like the change of instruments, and can see no advantage to be gained from its use.

Care should be taken in the withdrawal of the knife not to enlarge the portatic incision.

The most resisting point here is the bundle of firm tissue, which is described by LISTON as a fibrous band or ligamentous ring, surrounding the orifice of the bladder, and into which the muscular fibres of the viscus are inserted. This being nicked, however, the finger will be able to effect a dilatation.

The finger is now carried on into the bladder, the stone is found and the staff withdrawn. The warmed forceps are then slid along the finger through the opening, and attempts made to seize the stone. If it be grasped in a long diameter, try again, moving it about with the finger until the most favorable position is obtained. A small stone is easily extracted, but a large one will require a firm, steady, sawing pull, in order to give the opening in the prostate time to dilate; just such a motion, in fact, as is required in the delivery of a fœtal head.

A second cut is not necessary, even in a large stone—dilatation being preferable. Always search for remaining calculi or fragments, and remove them with the forceps or scoop; but do not introduce the instruments any oftener than necessary, for every bruise of the mucous membrane adds to the risk. Small fragments can be washed out by introducing a gum catheter through the wound and throwing in large quantities of tepid water.

Much difficulty is sometimes experienced in finding a stone; and in fact, eminent surgeons have sometimes given up an operation when it was afterward proven that a calculus was really present. You will probably remember how much difficulty I experienced in one of our cases last winter in this amphitheatre, the concretion having formed a pocket for itself of lymph, on the anterior wall of the bladder, directly behind the pubis. This encapsulation or encysting of calculus is not uncommon, and you should thoroughly explore every portion of the organ. They may even hang suspended by a band of lymph. Much benefit may sometimes be derived from strong pressure in the supra-pubic region, forcing the bladder down to the finger; or again, a finger in the rectum might render service. It is also well to remember that a small stone may escape with the first gush of urine.

When the stone is very large it may be crushed; but as a rule, it is well to avoid making any more fragments than possible, since they are difficult of removal and add greatly to the danger.

After all debris has been removed from the bladder, hemorrhage is controlled, and then comes the after treatment, which in uncomplicated cases is perfectly simple. The wound is left just as it is, no tube is passed into the bladder through the wound, no dressing is applied. The urine is allowed to escape through it at will and is received upon a sheet which is folded and laid upon one side of him, to be drawn under and rolled upon the other side as fast as it becomes wet. The bed is protected by gum cloth, and the patient permitted to lie in any position which is most suited to his comfort, the old rule of tying the legs together not being essential or advisable, especially in children.

Cleanliness is strictly enforced, and the sheet moved frequently, so that the danger of bedsores may be lessened.

The swelling of the lips of the wound may cause the urine to escape by the urethra for a few hours the following day, but after that time it is passed through the wound until it becomes so far closed by granulations at the end of two weeks as to cause the liquid again to assume the normal course.

The bowels should remain quiet until the fourth day, when an enema of castor oil may be given. Good air, a light room and nutritious liquid diet of milk and beef essence, are essentials. Numerous complications, inflammatory or otherwise, may arise, which should be individually and appropriately treated. Each case will differ in its course, and I have not now time to speak further upon the subject, nor to discuss the various other operations which have been performed for the extraction of these concretions.

The lateral operation was performed upon both patients. In the first case, the one in which the stone had existed from birth, it was found to be of enormous size, and required considerable force to extract it. It measured 6⅞, 5¼ and 5¼ inches in its several circumferences, and weighed more than thirty-eight drachms (2,300 grains). Moreover, it was found firmly imbedded in the bas-fond of the bladder behind the neck, having made a complete pocket for itself, and was so tightly adherent to the vesical walls that it required to be stripped out of its place with the finger, just as an orange is torn from its rind, being lifted up by placing a finger in the rectum. On section it proved to be an "alternating calculus," made up of layers of uric acid and phosphates, with a nucleus of the former

The strata were well marked and of various colors.

The patient did well for 24 hours, when pain, chills, and other symptoms of cystitis appeared, and, in a short time, the peritoneum in the immediate vicinity of the bladder seemed to become implicated; the pulse and temperature rapidly rising, and vomiting occurring. Turpentine stupes were freely applied, followed by continuous hot-water cloths, with one grain of opium every two hours, until the next morning, when three dozen American leeches were placed above the pubis. This seemed to check the progress of the inflammation, and it did not extend further over the peritoneum. The wound showed some tendency to sloughing for several days, but free nourishment and stimulants being given, the man rallied and is now, five weeks afterward, slowly improving, and is doing very well indeed, the urine already beginning to find its way out of the urethra.

In the second case the same incision was made, and a stone of the size of an English walnut, though more flattened in its shape, extracted. It was of a brown color, evidently uric acid, externally at least. It weighed 455 grains.

The bleeding was slight at the time, but when reaction came on, about four hours after, severe internal hemorrhage occurred from the prostate plexus of veins, which, coagulating in the wound, continued without any external bleeding until the bladder was filled and distended, so that a little finally forced itself out of the urethra. At the same time the symptoms of collapse, characteristic of internal hemorrhage, became apparent, and thrusting the finger into the wound, the bladder was cleared of a large quantity of clots, which had filled in whole interior. A gum catheter was now introduced, surrounded by muslin—the *canula à chemise* of DUPUYTREN—and the wound thoroughly packed around it. This effectually controlled the bleeding, and the man, though greatly weakened, yet has since done well, and was able to return to his home in three weeks, passing all his urine through the urethra.—DE F. W.

## PHILADELPHIA HOSPITAL.

Clinical Lecture on Primary Syphilis, by F. F. MAURY, M. D., Lecturer on Cutaneous and Venereal Diseases, in the Jefferson Medical College, etc.

*Delivered November 1st.*

[REPORTED BY DR. RALPH M. TOWNSEND.]

Agreeably to your request, and in place of our usual clinic, I propose, gentlemen, this morning, to give you some practical remarks in reference to the treatment of primary syphilis. In a large city like this you will not find medical men a unit as regards their treatment of this affection in all its stages, but all scientific medical men treat primary syphilis according to the rules I am now about to lay down for your guidance.

Chancre (a local lesion) and bubo constitute primary syphilis. The former may exist without the latter, but the latter must always be preceded by the former. Then again, we may have two varieties of the primary sore, viz., the chancroid, and the true, hard or Hunterian chancre. Certain characteristic features surround either of these conditions, and serve to distinguish them; and, moreover, these sores possess intrinsic differences.

After impure connection a man may suffer either from a chancroid or a chancre—unknown circumstances governing the development of one or the other. In the case of the chancroid, the period of development is more rapid, or, if you please, the state of incubation is shorter than in the chancre, varying from 5 to 10 or 12 days. As a general rule the chancroid is multiple, the ulcers being the seat of a profuse yellowish or drab-colored discharge, highly auto-inoculable, and the edges of the sores are undermined and surpigenous.

The period of incubation in the chancre is longer, and the sore itself is characterized by great hardness, due to plastic exudation around its base; not because the lymph itself is hard, but because the specific poison intimately blended or mixed with it, makes it hard. Let me call to your mind at this point that induration will follow the cauterization of a chancroid. The Hunterian sore, or true chancre, is generally solitary; its discharge, which is scant, is hardly as inoculable as that of the chancroid—certainly not so auto-inoculable.

What do we do then when a patient comes to us suffering from either of these sores? Is it our duty to then and there sit down and speculate upon the unity or duality of the syphilitic poison? No! Be it an abrasion, a crack, a fissure, a soft chancre or a hard, our duty manifestly is to destroy and eradicate it. How—by means of the nitrate of silver or *lapsis infernalis?* No! for surely a more infernal stone or remedy could not be brought into use at this stage of the disorder.

*Never cauterize a primary specific sore with nitrate of silver; it is not a caustic, but simply a stimulant and an alterant.* Use the mineral acids, such as the sulphuric and nitric, and the acid nitrate of mercury. For the chancroid the carbo-sulphuric paste is one of our best caustics; it stops the pus from spreading, and thus prevents auto-inoculation. This paste is made by taking of finely powdered willow charcoal and the strong, fuming, or Nordhausen, sulphuric acid, adding sufficient drops of the latter to reduce the former to the consistence of a paste. It must be made as wanted, for it will not keep; you apply this paste by spreading a quantity, of sufficient surface to cover the sore, upon a piece of lint or old soft muslin. If the chancre is under the foreskin, retract the latter, apply the paste directly upon the sore, and then when the foreskin is drawn back the lint comes between it and the paste, and thus prevents cauterization in a spot where it is not

wished. This paste is not allowed to be scraped off, but must remain until it comes away with the eschar, which is generally in about a week.

Another preparation is CANQUOIN's paste, made by adding together two parts of dry chloride of zinc, four parts of flour, and one part of glycerine. This is rolled into a layer from ¼ to ½ of an inch in thickness, and spread upon cloth; and thus when the caustic is applied, as in the previous case, it is prevented from coming in contact with anything but the sore. If the chloride of zinc deliquesces, which it is apt to do, it must be dried again.

These then are the caustics you must use—thorough agents, which do their work well. By cauterizing with nitrate of silver we merely cover up the plague spot, not destroy it, and thus allow our patient to become a subject of syphilis!

If my lecture but succeeds in impressing this one point upon you, you will be well repaid for coming here this morning. Another thing that you must rid your minds of is mercury in connection with primary syphilis. Remember, *you never give mercury with soft chancre, it but makes matters worse.* We give it in cases of hard chancre; not for its specific effect, but to promote, if possible, the absorption of the effused lymph. There are various theories afloat, however, regarding the action of the mercury in these cases. One is that it acts chemically, and destroys the syphilitic poison; another is that it is an emanant, and throws the poison from the system, and a third is that it simply neutralizes the poison.

To show you my precepts put into practice, I have two men before you, lying side by side upon the table, and each the subject of a primary venereal sore. The first case shows a chancroid in its granulating state, after having been touched with the acid nitrate of mercury. The second case is one of inflammatory chancroid, attended with suppurating bubo.

Both of these cases are complicated with long foreskins. There is less liability, however, of these men becoming affected with constitutional syphilis, than if they suffered from hard chancre. These cases where constitutional syphilis does follow the chancroid, may be due to a *mixing of the two varieties of syphilitic poison.* I have arrived at this conclusion after six years of active practice and observation. Particularly have I watched my cases in private practice where the statements of patients are more to be depended upon than in the hospital. I have treated cases of chancroid where no constitutional symptoms appeared in forty days—none in six years—and where the birth of perfectly healthy children attested the truth of my deductions.

During the past summer I paid a visit to the Indian Territory, and I find that several of the Indian tribes are almost exterminated by the ravages of syphilis. And you will find that wherever railroads, steamboats and stages go, there you will find gonorrhœa and syphilis. In a small town eighteen months old, and containing about 500 inhabitants, I ascertained there were forty-five prostitutes *and not a doctor!* Forty-three murders had taken place in the town since its settlement. Drovers from as far south as Texas meet in such a place, and desperadoes from everywhere. They have money and spend it with these prostitutes—they receive syphilis in return, and they scatter it broadcast. You will be called upon to treat these cases, and I want you to remember my teaching and treat them right. I was informed that the Comanches, the only tribe that has kept aloof from syphilis, legalize prostitution in the right way—they kill any of their women who have intercourse with the whites.

But to return to my subject: We come finally to the *experimentum crucis* in regard to chancre. Suppose a man presents himself before you with a sore on the penis, and you are unable to determine whether it be specific or non-specific, what will you do? Take a little of the matter on the point of your lancet and inoculate the man in some other portion of his body, not forgetting after doing it to stay on the safe side by cauterizing the original sore. If the latter was not specific, nothing will come from the inoculation; if it was specific you will have erythema on the first day, a papule on the second, a vesicle on the third, a pustule on the fourth, and an open ulcer on the fifth day. If you inoculate from a hard sore, the period of incubation will scarcely be less than three weeks. Now these facts, viz.: the relative period of incubation of hard and soft sores after both impure connection and inoculation, are reciprocally or mutually corroborative. By such means your diagnosis on the one hand is rendered correct, and on the other you take a load off your patient's mind, such that no words can describe. But do not be misled by what I have told you and inoculate those not the subject of the venereal poison, as did poor AUZIAS TURENNE one of RICORD's *internes.* Turenne in thinking over JENNER's discovery of vaccination, conceived the idea of inoculating everybody with syphilis so as to give them the disorder in a mild form. The matter was brought before the French Academy, and was promptly discarded and discountenanced by that body. DANIELSON, of Bergen, wound up a series of critical papers by asking Turenne why he did not inoculate himself. To this the latter made no reply; but when he died, two or three years ago, he gave his body to the French Museum, and upon examining it fifty-two ulcers were found upon its surface, where he had inoculated himself. Prof. BŒCK practiced what is denominated syphilization for the cure of constitutional syphilis, that is, inoculating and reinoculating the same individual all over his body, until the specific poison ceases to take effect. This is a disgusting treatment, to say the least of it. I tried it upon two patients

in this hospital, one recovered and went away —the other died.

Such, in brief, gentlemen, are some of the landmarks in this great venereal highway. You see that both these men before you have long foreskins, and that you will see in almost every case of syphilis that comes before you. A long foreskin serves to entangle and retain the specific virus, and after a patient has absorbed the poison, complicates the cure. Phymocise or circumcise, then, all the children you can, and thus decrease their chances of acquiring this disorder. It would not do to circumcise this man with the inflammatory chancroid now, because by so doing we would run every chance of inoculating the whole wound, and thus give him a ring of soft chancre. He must be treated, therefore, as best we can, cleanliness here being emphatically godliness. We will soak the entire penis in tepid water, medicated with permanganate of potassa, or carbolic acid properly diluted, and thus hope to expose the glans. This should be done four or five times daily, for ten minutes each time. Anodynes are often required to allay and prevent morbid erections. No mercury will be given.

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## JEFFERSON MEDICAL COLLEGE.

### Surgical Clinic of Professor Gross.

*October* 21.

[REPORTED BY DR. RALPH M. TOWNSEND.]

### Malformation of the Auditory Tubes.

A little girl was brought to the clinic from Franklin county, Pa., suffering with deafness, which affection, the mother stated, was the result of scarlet fever. The latter the child had while an infant, and before its inception the mother said the babe could hear well. There has been some discharge of bone from one side of the face, probably coming from the petrous portion of the temporal; and the small bones of one ear were said to have been discharged.

Examination revealed complete closure of both auditory tubes, the continuity of the skin being maintained over both membrana tympani. The lecturer stated that the uniformity of both the occluding membranes and the absence of anything like cicatrices, made him disbelieve the deafness the result of any disease, but that it was congenital. He had seen a thousand cases of ulceration of the tympanum, but never a case that resembled in its features the one before him.

A person thus affected need not necessarily be deaf, although the hearing must be more or less affected, as the cutaneous cover may be very thin. To make sure of the character of the occlusion an exploring needle or the point of a delicate knife may be carried down upon the membrane. This was accordingly done in the present case, and the instrument came directly in contact with bone, thus proving the truth of the diagnosis and showing the utter futility of attempting any remedial measures.

### Immense Varicose Veins.

Mr. Jones, from Iowa, æt. 53 years, has an affection of one of his legs, which is an extraordinary one of its kind. From supernutrition the vessels of his leg are immensely hypertrophied. The patient has been in this condition for the last twenty-seven years. The internal or long saphenous vein seems to be the one principally involved, seemingly as large as the abdominal aorta, and abounding in convolutions; but this is not the only affected vessel, as not only are all the superficial veins more or less enlarged and convoluted, but dissection would undoubtedly show enlargement of the deep venous trunks. If this internal saphenous vein were dissected out and its convolutions unraveled, it would be found to be much longer than the leg and thigh; and had not this patient taken the precaution to wear a lace stocking he would have suffered from so-called varicose ulcers, and probably would have perished. The term varicose ulcer, said Prof. GROSS, is bad. Ulcer of the skin complicated with varicose enlargement would be better nomenclature.

The disease of which this patient is the subject, may be caused in various ways. It is more common in women than in men, and is generally induced by the pressure of a distended uterus, constipation, tight garters, or by a substance creating mechanical impediment to the return of the blood in the venous channels. A similar effect is brought about by the habitual maintenance of the erect posture; and finally, a natural predisposition to varicose enlargement occasionally exists in certain individuals.

The veins of the inferior extremity are most liable to suffer, but those of the abdomen, vulva, scrotum, trunk and face are occasionally implicated; the veins of the superior extremity, however, are almost exempt from the disease.

In this connection, a definition of terms, often confounded, will be well in place.

*Varix* is a varicose and dilated state of the veins.

*Aneurismal varix* consists in a direct communication between a contiguous vein and artery, without the intervention of a sac. The cause is usually some external injury, such as a puncture, transfixing a vein and piercing the contiguous wall of an underlying artery. The orifice of communication is usually small and of a circular shape, the adhesion between the two vessels being firm as well as of considerable extent. The vein, from the impetuous manner in which the arterial blood is sent into it at each stroke of the heart, becomes greatly enlarged, both above and below the abnormal opening; acquiring, at the same time, unusual density, and pulsating with force.

*The arterio-venous, or varicose aneurism* consists of a tumor which is situated, as the name implies, between a contiguous artery and vein, so as to admit of a ready interchange of the two kinds of blood. It is generally caused by a puncture in bleeding, in which the overlying vein is completely transfixed along with the superficial wall of the artery. Sometimes the aneurism forms in consequence of ulceration, beginning in one vessel and gradually extending to the other, and so eventually establishing a communication between them through the intervention of a sac.

*Arterial varix* is a dilated and modulated condition of the arteries, similar to that of the veins, and hence very frequently described under the name of varicose aneurism. The lesion is rare and chiefly met with in the superficial arteries, particularly in those about the head, forearm, hand, leg and foot.

*Treatment* of varix is palliative and radical. The first consists in the avoidance of exciting causes, the use of cold ablutions, and rest of the limb in an easy, elevated posture. In varicocele, onanism must be interdicted; in varix of the hemorrhoidal veins, straining and constipation must be counteracted. A spontaneous cure is sometimes affected by thrombi being formed in the veins and occluding them; but oftener absorbtion comes into play and removes the clot. Giving artificial support to the affected veins by means of the bandage, lace stocking, etc., has a good effect; and in every form of the lesion benefit ensues from attention to the general health.

There are two principal methods for the radical cure of this affection; first, the establishment of a number of issues, with the Vienna paste (*i. e.* equal parts of quick-lime and caustic potassa) along the line of the affected vein; and, secondly, subcutaneous ligation by means of pins and ligatures. The Vienna paste should average remaining on the parts for twelve minutes, the patient being in bed with the limb in an easy, elevated position, and emollient poultices are afterward applied to aid in detaching the sloughs. The paste destroys the skin and subcutaneous cellular tissue, and produces clotting in the veins.

In the second method, that of ligating the veins, be careful not to transfix them, as erysipelas and death might result. A modification of this method is to enclose the vein in a loop of wire, which latter is afterward tightened.

### Scirrhus of the Mammary Gland.

Mrs. Buckley, a widow, æt. 50 years, has an affection of the left mammary gland. It was first noticed a year ago, as a hard lump in the breast, which has gone on gradually increasing. She was hurt in the same breast eight years ago. The breast was opened four months back, and now presents quite a large cavity at the place of incision. No caustic of any kind has been used. The nipple is but slightly retracted, guttered and somewhat prominent for this affection. There is some bleeding from the ulcer, the base of which is covered by greenish, aplastic lymph. Its edges are abrupt and slightly everted—undermined at points. Pain is present, and the patient winces when the parts are touched.

The gland is apparently not attached, as it is movable; but dissection would undoubtedly show strong attachments. The morbid action has, doubtless, extended through the gland to the pectoral aponeurosis and muscles, causing the outpouring of plasma and the making of strong adhesions. Removal of this gland would necessitate dissection of the aponeurosis down to the muscular fibres.

The retraction of the nipple in this, and kindred affections, is caused by the inflammation compressing the lactiferous tubes, and their subsequent contraction draws the nipple in with them. In this case, however, the ulcerative action has overcome the retraction. The remainder of the skin over the mammary gland is comparatively healthy; but the axillary glands are distinctly enlarged, as are also the glands along the lower border of the great pectoral muscles. Professor Gross stated that he had seen these glands the seat of the primary affection, but that usually the mamma was first involved. Taken altogether this is a remarkable specimen of carcinomatous disease.

The woman is pallid, feeble and thin, and her pain, severest at night, is stinging, sharp and shooting. Such is the pain of scirrhus, though sometimes it is dull and aching, and liable to be aggravated by various causes. This is emphatically a disease after the decline of the menses, the great majority of cases occurring between the ages of 45 and 50 years.

Lymphatic involvement here is owing to the secondary deposit of cancer cells, and hence this is an important fact relative to an operation.

In cases of scirrhus of the mammary gland it is not uncommon to find the lungs and pleura, the latter especially, involved. Involvment of the liver, uterus or ovary may also exist, or we may have tubercles of the skin.

This is not a fit case for an operation, unless relief from pain and the bad odor is aimed at.

This woman will be ordered twenty grains of the hydrate of chloral and the one-sixth of a grain of morphia, in solution, two hours before retiring to bed. She will also be ordered whisky, and twenty drops of the tincture of the chloride of iron, three times daily. To get rid of the bad odor from the breast, she will be given a drachm of the permanganate of potassa, dissolved in four ounces of water, and ordered to add a teaspoonful of this solution to a tumblerful of water, and wash the breast with it three times a day.

## ALBANY HOSPITAL.

**Surgical Clinic by Prof. J. H. Armsby.**

[REPORTED BY T. D. CROTHERS, M. D].

### Neuroma.

This man fractured both bones of his leg below the knee, four years ago. They united well, but a severe neuraligia followed over the fractured part. This increased until his health was seriously compromised. He desired an amputation; I refused; every other resource failing, he went to London, and the surgeon of St Thomas' Hospital amputated his leg. The stump healed, but the pain continued.

A year after, he came here again for treatment. I opened the stump, and found a neuromatous tumor on the end of the posterior tibial nerve. This was removed, and he went away. Two months after, he returned with the pain as severe as ever. I amputated above the knee, and found the anterior and posterior tibial nerves in the same condition.

A few weeks later, my colleague, Prof. HASKINS, who was in attendance, amputated at the hip joint. All along the course of the nerves were pear-shaped tumors, neuromata of various sizes. This was four months ago, but the pain continues; the wound is discharging, and the patients health is declining. The prognosis is unfavorable, medication is of little value, and nothing can be done but to make him as comfortable as possible. These cases are rare.

### Phagedenic Ulcer.

Here is a phagedenic ulcer with exuberant granulations, extending more than two-thirds round the leg; the surface is too large to expect it to heal over soon. I shall try skin-grafting. [With a scissors, small sections of skin were cut from the thigh, and fixed in different points of the ulcer by adhesive plaster.] These will form centers of new cicatrizations, and from these points, in every direction, new skin will extend.

### Gun-shot Wound.

This man was passing an alley on his way to business, when he felt a blow on the thigh, causing him to fall. Examination showed he was shot, the ball entering about three inches above the knee, on the outer side of the right leg. The ball seemed to have entered from below upward. Repeated probing failed to discover the ball. The wound did not heal. Two months after, I found an abscess pointing on the opposite side from where the ball entered; an incision revealed the ball, which was working down and outward. Previous to this I had enlarged the wound, and found a fissure in the bone made by the ball, but the ball was missing. These facts convinced me that the ball struck the bone, fissured it, passed up over it, lodging in the muscles, from which it was working its way downward and outward. The bone is dead about this fissure; the leg is enlarged, and the joint stiffened. Exfoliation of bone will follow, and an operation will be necessary, to cut down and remove the dead bone. The ball that entered the leg was fired ten yards up the alley in an opposite direction, evidently rebounding and skipping back along the pavement, striking this man. He is a strong, robust man, and will recover.

### Necrosis of the Femur.

This boy, now seventeen years old, fell three years ago, injuring the side and leg. He had lumbar abscess, then inflammation down the bone, periositis, ostitis, and now necrosis. The bone is enlarged, and from all these openings, called cloacæ, a free discharge is going on. Small fragments of bone have been thrown off, and I have repeatedly cut down and removed sequestra. The absorbents are very active in throwing off the disease. This is a remarkable case, the entire shaft of the femur is involved, and a free discharge has followed for two years. I have operated many times, and the disease still continues, yet his health seems unimpaired. This disease will terminate favorably after a time.

### Ligating Artery for Injury.

This boy cut his foot by stepping upon some glass. The hemorrhage that ensued was so severe that he was brought to this hospital from a village some fifty miles south. The bleeding was controlled by pressure. Three weeks afterward an alarming hemorrhage occurred, and I was obliged to tie the internal plantar artery. The wound is not healing rapidly. It is five weeks ago, and the foot is contracted inward. This is from inflammation and contraction of the tendons. There may be dead bone; the glass may have penetrated the bone. I shall put on a splint to keep the foot in a natural position. The secondary hemorrhage was unusual, and this injury apparently small at the time, may result in serious consequences.

### Quackery.

This woman has a bad ulcer on the right leg, of several years' duration. She came into the hospital a few months ago, and was successfully treated; the ulcer filled up, and was rapidly healing over, when she left to make a relative a visit. Here she met a distinguished man, who advertises that his extensive practice in all parts of the world has given him an almost superhuman power over disease. He advised her to use tinct. of iodine over the parts. You see the result—a deep, unhealthy ulcer. All the healthy granulations destroyed, increased in size, and the pain severe. This is worse than when she entered the hospital.

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## BELLEVUE HOSPITAL AT NEW YORK

**Treatment of Fractures by Plaster of Paris.—Preparation of Bandages.**

The ordinary bandage of coarse texture is well rubbed in with the dry plaster, then rolled up and set away for future use.

After four or five days, when signs of inflammation have subsided, it is usually deemed advisable to set up the fracture. Though, in some cases, this is done immediately upon admission.

The steps in the process are as follows:

1. Reduce as far as possible the fracture.
2. Cover the limb, from the extremity, with some soft substance, either cotton batting or piece of old blanket.
3. Retain this dressing by an ordinary roller.
4. Over this roller apply the plaster bandage, in a manner similar to any other roller. Previous to its application, however, it is to be soaked in water for ten minutes, or until it is completely saturated.

In three or four hours the plaster is completely solidified; but previous to that time care is required, to prevent malposition of fragments.

In fracture of the leg not much attention is required, but when the thigh is involved it is necessary to keep up extension and counter-extension, till the plaster case has hardened.

When the humerus is fractured, the bandage is to be carried up and over the shoulder, forming there a cap, but in fracture of the forearm, no special care is demanded.

In either rupture of the ligamentum patellæ or fracture of that bone, the parts are first to be adjusted as far as possible by means of strips of adhesive plaster extending above and below the joints; then the limb is treated in the same manner as for a fracture of the femur.

The advantages obtained by this method are, that it is needless for the patient to be in bed, after the plaster bandage has set, never beyond four or five days; that better results are obtained than by any other method, especially in fractures of patella and femur. In some cases, slight lengthening instead of shortening taking place in the latter bone; that there is no tendency to excoriation, and there is less chance for ununited fracture, inasmuch as the appliance fits perfectly, and is immovable.

Occasionally it happens that the toes or the fingers show signs of too tight bandaging, either from subsequent swelling or other causes. It is then requisite to make a clean cut through the plaster, along the anterior aspect of the limb, and when the symptoms have subsided, bind the cut bandage together by means of a firm roller.

# EDITORIAL DEPARTMENT.

## PERISCOPE.

### Scroto-Plastic Operation.

Dr. J. FULTON, M. R. C. S., Professor of Physiology, Trinity College, Toronto, writes to the *Canada Lancet:*

In the summer of 1869, while practicing in Fingal, Ont., I was called one day in a great hurry to see a patient, who was severely injured by a threshing machine. Upon my arrival at the patient's house, a distance of about 5 miles, I ascertained that he had not only received most serious injuries, but injuries of a peculiar and delicate nature. He had been standing astride the tumbling rod at its connection near the cylinder of the machine while oiling some parts of the gearing, and that inadvertently his pantaloons and shirt became entangled in the bolts and drew him down to the rod. Realizing his dangerous position, his placed he hands on the rod, and with a powerful bound freed himself from his entanglement, at the same time stripping himself of every article of clothing. At first he was scarcely aware of having received any injury; but the hemorrhage attracted his attention, and on examination it was discovered that the scrotum was entirely removed, and the integument of the penis torn from the root and reflected forward over the glans This was replaced by the bystanders, and he was taken up and conveyed home. The hemorrhage was not great, and very little constitutional shock was occasioned by the injury. Upon examination I found the whole of the perineal region stripped of integument, the scrotum entirely removed, and with it the left testicle, the cord of which was torn from its connection within the body. The right testicle and cord were laid bare, but otherwise uninjured. No serious damage was done to the urethra, and I was able to pass the catheter into the bladder, and remove a small quantity of urine. The remaining testicle being entirely free from any organic lesion, I felt it my duty not only to try and save it, but also to provide it with a suitable covering. True, it might have healed over, forming for itself a kind of integument, but this I felt would be a tedious process and would not form a very good covering when done, and therefore I decided at once to utilize a portion of the integument from the upper and inner surface of the corresponding (right) thigh.

The patient was put under the influence of chloroform and ether, and, assisted by Dr. MCLACHLIN, of Fingal, I proceeded to fashion a new scrotum for the *forlorn* testicle. I commenced the incision at the upper and inner

part of the thigh, at the anterior part of the perineal region, and carried it downwards to the extent of six or seven inches, then outward and upward toward Poupart's ligament, an inch and a-half external, to the situation of the cord. I then dissected up this portion of integument, which was oval in shape, from six to seven inches long, and from four to five inches wide, taking care not to wound the saphena vein. The flap so formed was next brought over the anterior surface of the testicle, made to surround it, and the edges stitched posteriorly throughout the whole length. A small quantity of adipose tissue was dissected up with the integument, and did good service in preventing any sloughing of the flap. The newly-formed scrotum was connected, as will be seen, by a neck an inch and a-half in width, which was sufficient to insure the vitality of the flap, and was sufficiently large to embrace the testicle comfortably. A small portion of integument was also removed from the left thigh, and brought across the perineal region, in order to facilitate the formation of integument in that part.

This might be considered almost a case of transplantation, although that subject had not as yet been discussed, much less put into practice. The wound in the thigh was partly brought together with adhesive plaster, and the patient put quietly to bed, and opium ordered to be given to allay the pain and procure rest. The stitches were removed on the third day, when adhesion was found to be tolerably complete. The patient made an excellent and rapid recovery. In three weeks' time he was able to move about the house, and in five weeks was able to attend to ordinary business.

I have been induced to report the above case on account of its rarity, and also because the operation I have thus described has never been performed in Canada, so far as I am aware. I have styled it a scroto-plastic operation. The principle upon which the treatment is based is not new; but its application in a case of this kind has not yet been recorded, so far as I have seen, and therefore I felt constrained to place this case on record.

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### Note on Pure Carbolic Acid.

Prof. CHURCH, M. A., writes to the *Chemical News:*

Since 1856 I have occupied myself a good deal with experiments as to the practical hygienic applications of carbolic acid, particularly as to its use in dentistry and in throat affections, and also as regards its employment as a disinfectant. The rank of carbolic acid as a most valuable contribution from chemistry to medicine, is so well assured that it is unnecessary to insist upon this point here. Yet there is an objection urged against this substance which has some apparent force, simply because the best preparations of commerce are so seldom free from a gas-like or naphthalic odor, which, though entirely foreign to carbolic acid itself, has condemned its use in some quarters. About 11 years ago, in preparing pure carbolic acid for the use of a surgeon dentist to whom I introduced it, I adopted a plan which I shortly after described before the Odontological Society, and to which I have been lately asked to give greater publicity. My plan, which is very simple, is as follows:

One pound of the best carbolic acid of commerce (I use Calvert's white crystallized acid) is poured into 20 pounds of cold distilled water, taking care not to permit the *whole* of the acid to enter into solution. With a good sample, if after shaking repeatedly at intervals, between two and three ounces of the acid remain at the bottom of the vessel used, this will be a sufficient residue to hold and contain all the impurities. With bad samples less water must be used or more acid. The aqueous solution should be syphoned off, and filtered if necessary through Swedish paper till perfectly clear; it is then placed in a tall cylinder, and pure powdered common salt added with constant agitation till it no longer dissolves.

On standing, the greater part of the carbolic acid will be found floating as a yellow oily layer on the top of the saline liquor, and merely requires to be removed by a syphon or pipette to be ready for use. As it contains 5 per cent. or more of water, it does not generally crystalize, but it may be made to do so by removing it to a retort, and distilling it from a little lime. The portion collected up to 185° C., or thereabouts, has at ordinary temperature scarcely an odor, save a faint one resembling that of geranium leaves; and I have taken advantage of this curious resemblance still further to mask the slight smell proper to absolutely pure carbolic acid, by the addition to it of four drops per fluid ounce of the French oil of geranium. This addition has the further advantage of liquefying the pure crystalized product.

The carbolic acid purified as above has been so highly appreciated by those professional and private persons to whom I have distributed samples, and who were dissatisfied with the purest commercial samples, that I have thought it best to publish my simple plan, for which, however, I claim no originality. It involves, I know, considerable loss of material, but the saline liquor remaining may be distilled, and thus made to yield up a second portion of pure carbolic acid, and it will be found a very pleasant and effective domestic disinfectant and deodorizer.

When dissolved in 230 parts of water and used as a gargle, or in twenty-five parts for painting the throat, or in fifty parts for a carbolic spray, the pure acid is rarely, if ever, objected to even by the most fastidious person. Of course it may be readily mingled with olive or other oil (1:25), or with glycerine, for dressing cuts and sores, and when intro-

duced into the little air-purifier invented by me and noticed in your columns some months back, diffuses wholesome and inoffensive vapor in any place where there are disagreeable effluvia of vegetable or animal origin.

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### Uterine Operations.

Dr. E. B. STEVENS says, in the *Cincinnati Lancet and Observer:*

The comparative impunity with which grave surgical operations have been performed upon the uterine structure, within a few years past, is something remarkable, in view of the revolutionized uterine surgery of modern practice. It may not be amiss, in this connection, to allude to one or two of these. For the relief of the obstruction produced by an irremediable anteflexion, the operation proposed by SIMS, and as modified by EMMETT and THOMAS, is to cut through one wall of the cervix, or remove a wedge of the wall, and thus substitute a straight canal for the crooked one. As just remarked, it is singular how little of unpleasant consequences has attended this operation; the philosophy of the suggestion seems plausible, but if we understand the recent reports of Dr. Emmett the results of the procedure have not been as satisfactory as was originally claimed or anticipated; and we suspect it will be found that much of the "cutting and carving" of this structure will ultimately be found to be far from the innocent character that ambitious gynæcologists seem to imagine.

Of the same character would seem to us to be *amputation of the neck.* Under certain circumstances there can be no question of its propriety, and the operation has been performed ever since the days of AMBROSE PARE; but for simple hypertrophied states and conical elongation, as is suggested, we cannot omit this occasion to express a word of deprecation. But to continue in detail a review of these surgical points would be needlessly to extend this paper. We will only notice one operation further that has been recently performed by Prof. Thomas, of New York, for the relief of obstructive dysmenorrhœa. Instead of making a rapid dilatation of the cervical canal by means of the hysterotome section, he proceeded simply to pare off, from about the os, a ring of tissue. Dr. Thomas claims both entire immunity from danger to the patient and successful results.

We turn to another field of brief inquiry: the relative opinions in reference to the safety of this sort of interference; and we find that Emmett and Sims have reported a tolerance of the gravid as compared with the unimpregnated uterine cavity to to the influence of foreign invasion which is remarkable. Ever since the pathology of the profession has become somewhat clear as to the nature of metritis and especially endometritis, there has been a strong feeling that some plan of intra-uterine medication must surely be best adapted to the rational and speedy cure of these cases.

Now, Dr. MENDENHALL, some years ago, reported the efficacy of applying persulphate of iron in solution within the cavity, for the arrest of post-partum hemorrhage; and other practitioners have adopted the same practice with safety; but here we have a fully dilated condition of the os, and there is no retention of the fluid. On the other hand, very small quantities of the blandest fluids have been forced within the uterus in the normal condition of the os and cervical canal, and frequently with the effect to produce terrible pain and symptoms of too grave a character to justify such procedure except upon most careful and guarded methods.

To this end we now resort to processes of dilatation. Dilatation of the cervical canal is accomplished in several ways and serves several useful purposes.

Means of dilatation are of themselves therapeutic as well as diagnostic; a dilating body is curative by virtue of the *pressure* it produces upon the cervical wall, and thus often itself is of advantage, aside from the additional means afforded for other applications. Dilatation enables the attendant to more satisfactorily explore the canal and the uterine cavity. Dilatation enables us to overcome the narrowed or constricted cervical canal, which frequently produces an obstructive dysmenorrhœa. Dilatation affords the necessary convenience of access for intra-uterine therapeutics, as well as means of exit for fluids simple or medicated which it may be desirable to introduce.

Dilatation has its dangers. It frequently causes pain; the dilator itself may produce irritation and inflammation.

The means generally employed are some form of tent or metallic bougie. Each has its advantages and objections. *The sea-tangle tent* is smooth, is readily introduced and free from irritation; but it dilates slowly and to a a limited extent. When there is no reason for haste it answers well, and its expansive power may be increased by inserting several slips of the sea-tangle side by side. *The sponge tent* is more frequently used; I prefer it myself because it accomplishes its work more readily, It is more liable to become charged with offensive fluid, but this may be corrected by proper medication, and the time necessary for retaining it is at any rate not very protracted. A more serious objection made by Dr. NOTT is the probable fact that the expanded sponge affords a surface of irritating points to the delicate tissues of an inflamed cervical canal; but I have never observed this result.

*The hysterotome.*—Some prefer to incise the cervical canal completely with the hysterotome, following with a large sponge tent. This is rapid and complete, but the process of cicatrization is likely to nullify the final result,

and, as a general procedure, seems to us objectionable.

*Metallic dilators.*—Instead of tents, metallic dilators are employed by some as the more satisfactory plan. Dr. Nott prefers a form of dilating forceps, which he describes in the *American Journal of Obstetrics* (November, 1869). Without any practical experience in this instrument, I should yet think it promises to be worthy of favor. But the graduated sounds, especially the set of curved sounds of Kammerer, seem the most complete instruments devised. They are so graduated as to present a small sound to commence the process, and the increased sizes may follow at such intervals as the judgment of the attendant may approve; operating precisely upon the same plan as the surgeon overcomes a strictured urethra.

But now having by some of these processes secured the free dilatation of the canal, we may, with comparative impunity, proceed to *wash out* the uterine cavity, and apply to its surface such agents, fluid or otherwise, as may be indicated.

The intelligent treatment of chronic endometritis now seems brought within comparative reach; we may bleed this inflamed surface, with Storer's scarificator, just as we would the delicate vascular structure of an inflamed eye; we may paint the surface with such alterants as chromic acid or iodine, or some of the various agents fitted to change or modify the condition of the living membrane.

But that which is particularly interesting is to feel quite well assured that with these preliminary precautions, we may inject this susceptible cavity for purposes of cleaning or medication, with scarcely any fear of the uterine colic, so liable to occur otherwise. In a number of cases in which I have injected the uterus with this previous dilatation, there was no more disturbance than from passing nitrate of silver into the cervical canal; scarcely so much.

# Reviews and Book Notices.

## NOTES ON BOOKS.

The *Oregon Medical and Surgical Reporter* is published in Portland, Oregon, and numbers among its editors and contributors some of the most energetic and intelligent physicians of the Pacific coast. It is no trivial undertaking to maintain a medical journal in one of our great eastern cities, hence the more credit is due those editors who combat successfully with the far greater difficulties of such a location.

Our attention has been called to the contrast between our notice of the "Odd Hours of a Physician, by John Darby," and the very favorable ones in other periodicals. As we do not claim to be infallible even in book notices, we can assure whomsoever it may concern that we shall be most happy to see our own favorable opinion dispelled by a hearty reception of the book by purchasers; and also, that if any errors of fact were contained in that or any other criticism in this journal, we shall most cheerfully admit their correction.

## BOOK NOTICES.

**A Manual of Midwifery, Including the Signs and Symptoms of Pregnancy, Obstetric Operations, Diseases of the Puerperal State, etc., etc. By Alfred Meadows, M. D., London. First American from the second London edition. Revised and Enlarged, with Illustrations. Philadelphia: Lindsay & Blakiston. 1871. 1 vol., 8vo., pp. 487. Price $3.00.**

This is a handy and useful volume, written primarily for the student of medicine, but sufficiently full on the branch of which it treats, to serve the purpose of a work of reference for the practitioner. The physiology of gestation and parturition is entered upon quite fully; the physiology of conception, and the development of the ovum are given a full consideration; pregnancy is embraced in the second part; while the third and fourth parts are devoted respectively to natural labor and obstetric operations. Unnatural and complex labor, and the diseases of the puerperal state, close the volume.

There are a number of well executed wood cuts, and the paper and type are excellent.

**Modern Medical Therapeutics: A Compendium of Recent Formulæ and Specific Therapeutical Directions. By Geo. H. Napheys, A. M., M. D., etc. Third Edition. Revised and Improved. 1 vol., 8vo., cloth, pp. 496. Price $2.50.**

The cordial welcome extended to the two previous editions of this work, insures for the present one an early distribution among the profession. Over seventy pages of recent and carefully culled material have been added, and the formulæ and directions previously given, rigidly revised, and in great part re-written. In its present form the work deserves to be more than ever the physician's vade-mecum.

MEDICAL AND SURGICAL REPORTER

PHILADELPHIA, NOVEMBER 25, 1871.

D. W. BUTLER, M. D., D. G. BRINTON, M. D., Editors.

☞ Medical Society and Clinical Reports, Notes and Observations, Foreign and Domestic Correspondence, News, etc., etc., of general medical interest, are respectfully solicited.

Articles of special importance, such especially as require original experimental research, analysis, or observation, will be liberally paid for.

☞ To insure publication, articles must be *practical, brief* as possible to do justice to the subject, and *carefully prepared*, so as to require little revision.

☞ Subscribers are requested to forward to us copies of newspapers containing reports of Medical Society meetings, or other items of special medical interest.

We particularly value the practical experience of country practitioners, many of whom possess a fund of information that rightfully belongs to the profession.

The Proprietor and Editors disclaim all responsibility for statements made over the names of correspondents.

## THE REPORTER—1872.

We have everything to encourage us to begin the year 1872 with **energy** and a determination to make the MEDICAL AND SURGICAL REPORTER *a better journal than ever*. The past has been by far the **best year** it has ever known. Its **circulation** has steadily increased, and is increasing. We have every reason to believe that we shall add **one thousand new subscribers** to our list in the next three months, **outside** of the direct efforts of our present subscribers. ☞ Let *them* exert themselves and **our list will be doubled in that time.** Come, friends, try it now, and benefit yourselves and the cause of medicine by strenghening our hands! Always get the $5 in advance and then retain one dollar cash for every annual payment from *new subscribers you send*, or order $1.25 worth from our office in books, instruments, etc. *If you work for us we want to pay you for it.* Five new subscribers will pay your own subscription, or get you $6 worth of books, etc. Our present subscribers are the best agents we can have, for they know the worth of the REPORTER. Now, be active in the next four weeks—and let us start the new year with a **rousing list of new subscribers!!**

But no picture is perfect without shades! A good many subscribers—some of them personal friends of long standing—are owing small amounts for subscriptions, which aggregate a very large amount. To them we commend the inclosed special notice.

## AN ENGLISH OPINION ON MEDICAL ETHICS.

Not unfrequently we are called upon to express our opinion on the propriety of certai steps taken to secure practice by medical men. We always do so with hesitation, for, unacquainted as we are with the circumstances, it is easy to judge harshly.

The *Lancet* has lately rehearsed the principal difficulties which present themselves, and although the *Lancet*, neither in its history nor in its present management, is by no means a model journal so far as ethics are concerned, it touches "with a needle" some troublesome questions.

The following points are adverted to, among others, as of frequent occurrence:

*Disregard of the difference between a trade and a profession.*—The essential distinction between a trade and a profession is in the nature of the service to be rendered. In the case of trade there is an exchange of wares for money; in the case of a profession, opinion, advice, or skilled judgment is the essential commodity to be exchanged. And some men cannot receive this pure professional idea of service. Perhaps it arises from a modest diffidence as to the value of anything they have to offer the public in the way of opinion or judgment, and so they supplement the real professional commodity with something more tangible. They deal in actual wares—such as tooth-brushes, soaps, perfumery, cholera mixtures, etc. Medicine is no longer a trade even in drugs. Practitioners are under the occasional necessity of supplying drugs to their patients because druggists have not yet discovered the art of dispensing prescriptions on practical terms. But this is a mere accommodation to their patients, and not of the essence of their service.

*Inadequate sense of the value of medical service* is another note of something ethically wrong in a man's notions of practice. A man may think his own professional services paid by low fees; but he lowers his profession in the eyes of the public, and is justly blamed by his professional brethren. There is an undertaking to uphold the dignity of the profession which is not observed by such practices. We have great respect for all earnest attempts to supply the workingman with good medical attendance on terms which are practicable; but it is not to be done by private practitioners advertising their services as available for all and sundry on terms which would scarcely pay a respectable druggist.

*The love of publicity and advertisement* is a third note of an unprofessional spirit. It is sad to think of the numbers of instances in

which handbills, circulars, cards, or testimonials, are scattered broad-cast, advertising the terms or abilities of pushing practitioners—men who have come in to a neighborhood and cannot trust to their own abilities to obtain patients.

Then there is a prevailing eagerness to get and keep the patients of other medical men, and a not less prevailing unwillingness to spare the feelings and reputation of rival practitioners. The limits to practice are fixed by nature. Only a certain number of sick are in a community, and unfortunately (for the business of the physician) the only possible way to increase his income is to secure the patients of others. There is no "stimulating trade" in medical practice. Hence the personal jealousy and bitterness so often characterizing the profession, especially in small towns.

## Notes and Comments.

### Appointment.

Dr. R. D. MURRAY, of Cleveland, Ohio, has received the appointment of surgeon and microscopist on the U. S. survey steamer, A. D. Bache, recently built, and which will be stationed at Key West, Florida. An important position, which we believe will be creditably filled by Dr. Murray.

### The Cost of Small-Pox.

The following is clipped from a late number of the London *Pall Mall Gazette*. We respectfully invite for it the consideration of our Board of Health:

Dr. LANKESTER, in his report to the vestry of St. James, Westminster, says: "The small-pox is now slowly departing from the metropolis, after slaying five thousand persons, and maiming, disfiguring and pauperizing about one hundred thousand more. It must have cost the metropolis at least £100,000, *a tenth part of which sum judiciously expended would have cut short this epidemic at its very commencement.*

### Effects of a High Temperature.

The effects of heat upon animals has recently been the subject of a number of curious experiments made in France by CLAUDE BERNARD. Heat, it appears, when it reaches too high a degree, operates like poison, destroying feeling and motion, arresting the action of the heart and circulation, and thus necessarily producing death. The degree of heat which must not be exceeded is from 115 to 120 degrees Fahrenheit for cold-blooded animals, 129 to 131 degrees for mammalia, and 140 to 144 degrees for birds. In each separate case the maximum differs by a few degrees only from the normal temperature of the animals. The precise action of the heat upon the blood is thus described:

The blood of an animal killed by heat becomes black, and the oxygen it contains is rapidly transformed into carbonic acid, and finally disappears. This change, however, is not a true toxical action, but rather an excitement of the vital properties of the red particles. The black blood of a rabbit killed by heat is still living, will absorb oxygen by contact with the air, and again will become ruddy. Between 197 and 190 degrees, however, the blood coagulates, loses its vital properties, and cannot again become red. Above a certain degree heat kills the muscles without killing the blood. The chemical character of the poisoning of the muscles by heat has not been ascertained, and the phenomena accompanying the muscular rigidity and abolition of motion remain to be analyzed.

### Horse and Dog's Flesh.

One who had experience during the siege of Paris says:

Horse flesh "looks and tastes exactly like beef, and not only with difficulty can be distinguished from it, but is in fact preferable to it. It is better, however, the same as cat meat, to put it in pickle for thirty-six hours." Dog meat, when properly prepared, resembles mutton and even deer. Dog *cotelettes* and dog *filet* are preferred.

### Simple Test for Arsenic, Antimony and Phosphorus.

The solution of the substance to be examined is first considerably diluted with water, and poured into a wide-mouthed bottle, to the cork of which are fastened a number of pieces of parchment paper, previously saturated in acetate of lead, nitrate of silver, and sulphate of copper. A few drops of sulphuric acid are now added, some pieces of zinc thrown in, and

the cork put on. In case any gases are liberated, they will react upon the strips of paper, and the color will disclose to what particular element the reaction is due. Phosphuretted hydrogen does not blacken nitrate of silver and acetate of lead, but does act upon sulphate of copper. Antimonetted and arsenetted hydrogen do not affect the nitrate of silver and sulphate of copper, but blackens the lead salt. Sulphuretted hydrogen, however, blackens all three of the above metallic solutions. In order to decide what elements are present, the strips of paper are to be macerated in a solution of cyanide of potassium. If the coloration immediately disappears, it was due to sulphuretted hydrogen; if it slowly changes in cold and more rapidly in heat, it was caused by phosphorous or antimony; if it only bleaches a little and turns brown, and does not disappear when heated, it may be traced to arsenic. For ordinary purposes and rapidity of work, this method appears to be sufficiently accurate, and will enable the operator to dispense with the more cumbersome Marsh apparatus.

## Correspondence.

### DOMESTIC.

#### Medical Chits.

EDS. MED. AND SURG. REPORTER:

Little twigs, indeed, are the acknowledgments due the many ardent searchers for the better understanding of "*how to be a successful warrior, battling with disease.*"

Of the many fields so bravely held by the MED. AND SURG. REPORTER, was none so lucrative as the controversy between Drs. CORSON and SNYDER, to the attentive bystander; but we think that the question should be settled in a little more satisfactory manner to the parties concerned, and to generalize upon this special case, let us try to find the reason why such has not been done.

We assume the right of asserting, that this is owing to an evil existing priorly in the relation that physicians are mostly forced to hold toward their patients. How often have we urged upon them the necessity of reporting to us the effects of the remedy prescribed, and how seldom is the response to our bidding.

We give again and again a medicine, trusting to its efficacy, and in administering it, which we had petted so much and so long, to one dear to us, one in whom we take a particular interest, say a brother physician, we find, *that it proves only too false:* our friend pays *our trust* with *his life*, and we, with weeping eye, lay aside the broken sword, only to take up the next one, for the same purpose and with the same success. Thus it happens, that the young and ambitious physician has a hundred remedies, and the gray-haired practitioner only ten medicines to depend upon.

Some say, excepting perhaps quinine in malaria, mercury in syphilis, and sulphur in itch, we have no remedy that could be named a specific; we think, *that no article becomes a true medicine, except it deserves the title* SPECIFIC. For it is only in *that* peculiar abnormal condition of *the* specific change of cell structure, that *this* remedy will assert *its* healing influence and—do you wish a better definition of the word SPECIFIC?

We will here not speak of the specific use of opium, belladonna, ipecac, tartar emetic, quinine and taurine to which we laid claim in the pages of this journal, and draw your attention only to Dr. CORSON'S *specific for scarlatina*. *A priori*, however, we deem it but an act of justice to note, that we saved, to our honest conviction, the life of one human being through the instrumentality of Dr. CORSON'S remedy, the credit belonging to him and the MEDICAL AND SURGICAL REPORTER.

Last spring I was called to the house of Mr. N., of this city, and found three patients, two daughters, aged respectively 22 and 10 years, and a son about six years old, all of whom presented symptoms, more or less severe, of *diphtheria*. No pleasant sight, but less troublesome by the trust in my *good will* to help. The intelligent mother was directed to make *ice cream*, procure *ice*, and feed the former and apply the latter to the necks of the sufferers (*a la mode de* Dr. CORSON) and permit them the use of ice, as their thirst should call for it. The good nurse shook her head a little, owing to a case, in the same family, four years ago, which we treated quite differently at the time, the patient surviving in spite of the doctor. She set at work, nevertheless, to do our wishes, and we went our way, feeling like a student 15 minutes before his final examination for degree. Next morning we came, and wished Dr. CORSON or Dr. SNYDER had been with us. The miracle wrought by ice and ice cream was almost too wonderful. Our family thought nobody ever did the like, and we permitted them to think so. In a few days all three were perfectly relieved of the trouble, and have not suffered the slightest inconvenience since from that source.

In June, a little six-year old boy sickened with scarlet fever, and, though being attended by allopathy, homeopathy and other "pathies," died of the disease. This being transplanted into the next house, took with it a younger child; almost all the members of both families, as far as I could ascertain, suffering from scarlet fever or sore throat, at the same time, and later. In the third house from starting point, or next house to the last named victims above,

it infected a 15 year old boy, whom I had attended 3 years ago with typhoid fever, which he stood very bravely; but this time he soon went from bad to worse. We had read Dr. CORSON'S letters in regard to this matter. This, and the knowledge of some of the medicines given to the other cases, gave birth to the resolution: NO MORE OF MEDICINE THAT FAILS, *and something that has not had a chance of failing as yet.* Our patient presented a most discouraging condition. When we saw him, he was in delirium, had sores on lips and gums, and exudate from the ulcerated throat, that almost prevented the respiratory process; high fever and incontinence of the excrements, and, worst of all, a step-mother that cared little for him, who, with her lady friend, pronounced the patient a dead boy. With this material we set to work, with the aid of the father in enforcing our directions. We put him into a *cool* bath, which brought him quickly to his senses (by the way, we found this the best remedy in delirium of typhoid fever); then we applied ice to the neck and—*kept it there*, permitting him ice and ice-water to quench his thirst. No medicines. Next morning the throat was somewhat better—this affection seeming the greatest danger to the life of the boy—but the body was weaker; in consequence gave small doses of quinine in tinct. ferri chlori, and ordered beef tea, eggs, and a little brandy. In the evening he was a little more feverish, therefore gave the bath, and again with no more medicine, than above mentioned, we had the great pleasure of seeing our patient live and grow strong in body, and in his confidence of *our treatment* (Dr. CORSONS). We omitted a a minute description of the disease as it was the same presented in any patient sick with a grave form of scarlatina, only laying stress upon the treatment, its being a specific for the same—ICE *or its equivalent*—cold.

We beg pardon for diverging from our subject, "the medical chits," into the chats too widely, and close with the remark, that what we said in regard to the physician and his relation to the patients holds true for their intercourse among themselves. Had I sent these lines two months sooner, Dr. CORSON'S latest article would have had one proof more for its excellency.

Are there not many more physicians who read the REPORTER, and, with me, tried the above treatment? What has become of their experiments and its consequences? *Where are their chits?* Whenever they are directed to the right quarters, they seldom fail to create the grand tree, under whose foliage we may rest secure in the performance of our noble calling, if, perchance, a hail-storm surprises us on our way.

A. S. VON MANSFELDE.

*Chicago, Ill., Nov.* 8, 1871.

### A Remarkable Family.

EDS. MED. AND SURG. REPORTER:

The following history of a remarkable family comes to me from Kentucky, so well authenticated that I send it for publication in the REPORTER. I am much mistaken if it is not one of the most extraordinary on record:

About one mile from Jamestown, Russel county, there lives one of the most remarkable families in all this commonwealth, and probably in the United States. Mr. James Jeffries, who is now in this city, serving upon the petit jury in the United States Court, tells his own story, and says that he was married before he was seventeen years old, his wife being only five days younger than himself. They lived together seven years without children when his wife gave birth to twins, a boy and a girl. In the fifteen years which followed, nineteen children were born to the happy couple, each of the first three births being twins, and each subsequent birth alternating between twins and single births, until the fifteen years were accomplished and nineteen children composed the family circle, seven pair of twins being born during the time.

Mr. Jeffries is only forty-five years old, and is still youthful in appearance and very stout. His wife never had better health in all her life than at present, though she will not weigh a hundred pounds. Her greatest weight at any time was a hundred and ten pounds. The boy of the first twins now weighs a hundred and sixty-five pounds, the girl a hundred and twenty-five pounds. All the boys who are grown have made large men; the girls are of good size and all the children healthy. But five out of the nineteen have died. Mr. Jeffries has ten brothers, all of whom are large men, and within the families of these eleven brothers there are thirty-seven pairs of twins, making seventy-four twin children, to say nothing of the host of single births. Five of Mr. Jeffries' children are married, and, added to all these singular facts, notwithstanding the absence of silvery locks on his head, he is the grandfather of five children.

*Peakskill, N. Y.* CHAS. A. LEE, M. D.

### Half Blonde and Half Brunette.

EDS. MED. AND SURG. REPORTER:

A singular freak of nature fell under my notice long ago, and of which I have frequently thought I would make a note, and do it now. A young lady acquaintance, and one whom after her marriage I several times saw professionally during her peril, was half blonde and half brunette. The right side was fair complexion, blue eye and light colored hair. Left side dark complexion, black eye and dark colored hair. This female is still living, probably some sixty-five years of age, and the mother and grandmother of a numerous progeny. Her physical singularity was not propagated.

Apples half sweet and half sour are said to be propagated, by carefully inserting the half of a sweet and sour bud together. How was this human freak accomplished?

L. G. HARLEY, M. D.

## News and Miscellany.

### The Health of Baron Liebig.

From a private letter received in this city, we learn that Professor Liebig is by no means restored to his former physical and mental activity. He spent the early part of the summer at the baths of Kissingen, and was much benefitted by the treatment; later in the season, he went to meet a few choice friends, among them his life long colleague, Professor Woehler, at Reichenhall, where one of his sons is a physician; and here, in the invigorating mountain air, his bodily infirmities disappeared; but he complains of dizziness and suffering whenever he attempts the least mental exertion. We fear that the illustrious chemist will hardly be able to enrich our literature with many more of the brilliant writings which have rendered the science, to which he has devoted the best years of his life, so useful and so popular.

Liebig may be justly called the founder of modern chemistry. It was he who first organized laboratory instruction, and rendered it possible for pupils to pursue experimental science in an experimental way. This has been his chief service, but another almost equally important contribution to the cause of learning has been the popularization of science accomplished by his writings.

### Birthplace of Cholera.

An English army surgeon, writing to the London *Times*, traces the supposed impending visit of cholera to a "monster religious meeting" on the Ganges. He says that he was in one of the worst cholera districts in India, in the year 1867. Preparations were then making for a gathering at Hurdwar, on the Ganges. The medical officers of the army warned the Government of the danger of such an assemblage. The authorities could not, or would not interfere. The multitude assembled, in number about 360,000. In forty-eight hours after the gathering the cholera broke out among them. The multitudes, panic-stricken, scattered, north, south, east and west, carrying the seeds of the disease with them. From this beginning, and not from Persia, this writer contends the cholera is spreading. Persia received its infection from the assemblage on the Ganges. The writer says that these monster meetings are held at stated times. If some one could furnish data by which it could be shown that the "meetings" and the outbreaks of cholera occur in the same year, the case might be made out.

### Well Merited Punishment.

The infamous Rosenzweig, the murderer of Alice Augusta Bowlsby has been sentenced to eight years confinement at hard labor in the State Prison. His diploma, it appears, was granted him, no doubt, after the *usual* examination by the Eclectic Medical College of this city.

——Recent letters from Calcutta state that at the last public sales opium brought the highest price it has reached for three years, having sold at $702 a chest. The prospects of this crop in 1872, in India, it is said, are not encouraging, while the short crop of the year 1871 has the natural tendency to raise the price of the existing stock.

——It is recorded of Radcliffe, that in 1691, when his fame was so great that everybody flocked to him for advice, that his neighbor, Dr. Gibbons, received £1000 a year—a large sum in relation to the value of money at that period—from the overflow of patients who were not able to get admission to the great physician of the day. In 1707—seven years before his death—his fortune amounted to £80,000.

——Says the *Gartenlaube:* The Americans understand better than we how to give an appropriate covering to everything they use. Their medicines and drugs, for example, are met with in all quarters of the globe, not because they are superior to ours, God forbid, the contrary is often the case, but because their boxes and bottles are neatly inclosed and labeled, so that they can constitute an ornament for every drug store, and are, at the same time, easily opened and yet air-tight.

——The Babylonians, having no physicians with whom to consult in case of sickness, adopted a novel plan to obtain relief under such circumstances. They had the infirm brought into the Forum, and those who passed by were asked their opinion as to the nature of the disease. They demanded of each one if he ever had the same distemper, if he knew any one who had had it, and, if so, how he was cured.

——A sewage scheme has been adopted by the corporation of Birmingham, England, to exclude injurious matter from the sewers, and to purify the sewage by filtration upon an area of 900 acres of land. The cost of the scheme is estimated at $1,500,000.

——Dr. H. Alleyne Nicholson, formerly lecturer on Natural History in the Medical School of Edinburgh, has been appointed to the Chair of Natural History in the University of Toronto.

——Professor Wurtz has stated to the French Academy of Sciences, that the nitrate of strychnia, used hypodermically, is an antidote to the poisonous effect of chloral.

——The best method of destroying bugs is to wash the wood-work infected by these vermin with a solution of carbolic acid in water the strength of five parts of the acid to one hundred of water. The insects are at once killed by the solution, which also acts as a disinfectant.

### Inunction of Newly-Born Infants.

At a recent meeting of the Lynn Medical Society, Mass., says the *Cosmos*, Dr. Nye spoke of the management of the child after birth, and reported one case which died of too long exposure in being washed, and another that was chilled and livid, but was saved by the hot bath. He recommends that the child be covered with lard and wiped, no water being used. In two recent cases we have substituted inunction for washing of the infants, not only at the time of birth, but long subsequently, with manifest advantage. Fresh lard was used, and seemed both to protect and nourish the children, as they were very healthy and grew finely.

## WORDS OF ENCOURAGEMENT.

*Dr. S. H. S., of Ind.*, says: "Let me say, by way of encouragement, that I consider the ability of the MEDICAL AND SURGICAL REPORTER unsurpassed, that it brings us up with the times once a week."

*A Surgeon of the U. S. Army*, on the frontier, writes: "Of all the medical journals I read, the REPORTER is in my humble opinion the most useful and practical, and so long as can spare the money to procure your valuable journal you may regard me as a subscriber."

*Dr. G. S. G., New York.*—"No consideration whatsoever, could induce me to dispense with any of your valuable publications."

*Dr. J. K. L., Ind.*—"I would dispense with my daily paper, before I would do without your weekly journal."

*Dr. F. S. H., Maine*, says:—"I am more pleased with the REPORTER and POCKET RECORD, than with any other visiting list or medical journal."

*Dr. J. G. M., Mich.*, says:—"I would not be without the REPORTER if it cost twice the amount of subscription."

## QUERIES AND REPLIES.

### Hamilton on Fractures.

*Dr. J. H. P., of Pa.*—The price of the last edition of this work is $5.75 cloth, $6.75 sheep.

### On Veterinary Art.

*Dr. H. W. L., of Wis.*—The best works on the Diseases, &c. of the horse, are Morton's *Veterinary Pharmacy*, $5.00 and Prof. Gamgee's *Veterinarian's Vade Mecum*, $5.00, both English works.

### Comparative Anatomy.

*Dr. A. J. E., of Ohio.*—The most complete work on this subject is Owen's *Comparative Anatomy of the Vertebrates*. 3 vols. $36.00. Dr. Allen's small hand book of Comparative Anatomy, is $2.00.

### Flint's Practice.

*Dr. W. E. W., of Del.*—Flint's Practice, cloth, costs $6.00. Binding the REPORTER costs $1.00 per volume.

## OBITUARY.

### DR. DAVID STANTON.

This gentleman who was recently elected Auditor General of Pennsylvania, died suddenly at his residence, New Brighton, Sabbath morning, Nov. 5. He had been suffering with a neuralgic complaint for several days. He injected a small quantity of the solution of sulphate of morphia into one of his arms for the purpose of allaying the pain. He soon sank into a tranquil sleep—but he never awoke. It was his long, last sleep. Several of his medical brethren were called to his bedside. They sought to cause a reaction, but their labors were in vain. It is their opinion that the deceased punctured a blood vessel while introducing the narcotic, and which, owing to the peculiar state of his system, caused death to ensue.

The deceased was a son of the late Dr. Benjamin Santon, of Ohio, and a nephew of the late Secretary Stanton, to whom he bore a striking resemblance. He was born in 1829, and after studying medicine, and graduating at the Cleveland Medical College and the University of Pennsylvania, removed at the age of twenty-one, to New Brighton, Beaver county, where he commenced the practice of medicine and has continued to reside.

In August, 1861, he entered the army as surgeon of the First Pennsylvania Cavalry, and was connected with the army of the Potomac until promoted to the post of surgeon of United States Volunteers, in November, 1862, from which date, until he resigned, in December, 1865, he acted as superintendent of hospitals, and as assistant and acting medical director of the Northern Department, on the staffs of Generals Heintzelman and Hooker. In 1864 he was breveted lieutenant colonel, and in 1865 was made brevet colonel.

## MARRIED.

GRAY—MCCANDLESS—By Rev. S. J. Wilson, D.D., October 26, at the residence of the bride's parents, Pittsburgh, Pa., Mr. P. R. Gray and Miss Lizzie J., daughter of Dr. A. G. M'Candless.

HALL—HOWE—In Boston, Mass., Nov. 15, at the residence of the bride's parents, by the Rev. Jas. Freeman Clarke, David Prescott Hall, of New York, and Florence Marion, second daughter of Dr. Samuel G. Howe.

JONES—NEAL—In Kittery, Maine, Nov. 3, by Rev. A. W. Pottle, Dr. D. W. Jones, of Ellensburgh, N. Y., and Miss Fanny E. Neal, of Kittery.

PATTERSON—GOLDSMITH—Nov. 15, at Trinity Church, Rutland, Vermont, by the Rev J. H. Ely, assisted by the Rev. William J. Harris, Joseph Steven Patterson, of Philadelphia, and Mary Middleton, daughter of Dr. M. Goldsmith, of the former place.

PHILLIPS—WILLIAMS—By Rev. E. K. Squier, D.D., October 21, Mr. Warren W. Phillips, of Upper St. Clair, Pa., and Miss Lucy M., daughter of Dr. J. B. Williams, formerly of Pittsburgh.

## DIED.

BECK—Isabella, wife of Joseph Beck, M. D., died at Eldorado, O., November 3d, 1871, of consumption, aged 41 years, 2 months, and 27 days.

CROOKSHANK—In Cincinnati, November 11th, at 11 o'clock, P. M., of consumption, Katie, daughter of Dr. E. D. and Mary Crookshank, in the 24th year of her age.

DEVENDORF—On Nov. 13, residence 513 Grand st., Williamsburgh, Edward Devendorf, M. D., aged 52 years.

FAIRBANK—At Highttown, N. J., Nov. 6, J. N. Fairbank, M. D., in the 48th year of his age.

FOOTE—Dr. Charles C. Foote died in New Haven, Conn., on the 9th inst., of hemorrhage. He was a native of Jamestown, N. Y., and a son of the Hon. E. T. Foote, a prominent physician of Chatauqua county, and for very many years first judge of that county.

RIDGEWAY—Dr. Charles Ridgeway, a well known resident of Burlington county, New Jersey, died at his residence near Jacksonville, recently, in the 81st year of his age.

WRIGHT—In New York, on the 17th inst., Fannie A., daughter of Dr. S. and Carrie Wright, aged 7 years and 10 months.

DAVIS—In Laconia, Harrison county, Indiana, Nov. 8, 1871, Grace Trueman, youngest daughter of Dr. J. T. and Sarah C. Davis, aged 1 year, 7 months, and 28 days.